C.L. BUTCH OTTER, GOVERNOR RICHARD M. ARMSTRONG - Director

DEBRA RANSOM, R.N.,R.H.I.T., Chief BUREAU OF FACILITY STANDARDS 3232 Elder Street P.O. Box 83720 Boise, ID 83720-0036 PHONE 208-334-6626 FAX 208-364-1888

CERTIFIED MAIL: 7007 0710 0002 7979 0352

December 18, 2008

Chad Mangum Access Home Care 190 West Burnside Avenue, Suite E Chubbuck, Idaho 83202

RE: Access Home Care, provider #137110

Dear Mr. Mangum:

Based on the Medicare/Licensure survey completed at Access Home Care on December 3, 2008, by our staff, we have determined that Access Home Care is out of compliance with the Medicare Home Health Condition of Participation on Organization, Services & Administration (42 CFR 484.14) and Acceptance of Patients, POC, Med Super (42 CFR 484.18). To participate as a provider of services in the Medicare program, a Home Health Agency must meet all of the Conditions of Participation established by the Secretary of Health and Human Services.

The deficiencies which caused this Condition to be unmet, substantially limits the capacity of Access Home Care to furnish services of an adequate level or quality. The deficiencies are described on the enclosed Statement of Deficiencies/Plan of Correction (CMS-2567). A similar form indicates State Licensure deficiencies.

You have an opportunity to make corrections of those deficiencies which led to the finding of non-compliance with the Condition of Participation referenced above by submitting a written Credible Allegation of Compliance. Such corrections must be achieved and compliance verified, by this office, before <u>January 16, 2009</u>. To allow time for a revisit to verify corrections prior to that date, your Credible Allegation must be received in this office no later than <u>January 8, 2009</u>.

Chad Mangum December 18, 2008 Page 2 of 3

The following is an explanation of a credible allegation:

Credible allegation of compliance. A credible allegation is a statement or documentation:

- Made by a provider/supplier with a history of having maintained a commitment to compliance and taking corrective actions if required.
- That is realistic in terms of the possibility of the corrective actions being accomplished between the exit conference and the date of the allegation, and
- That indicates resolution of the problems.

In order to resolve the deficiencies the facility must submit a letter of credible allegation to the Department, which contains a sufficient amount of information to indicate that a revisit to the facility will find the problem corrected.

As mentioned above, the letter of credible allegation must indicate that the problems have been corrected as of the date the letter is signed. Hence, a plan of correction indicating that the correction(s) will be made in the future would not be acceptable. Please keep in mind that once the Department receives the letter of credible allegation, an unannounced visit could be made at the facility at any time.

Failure to correct the deficiencies and achieve compliance will result in our recommending that CMS terminate your approval to participate in the Medicare Program. If you fail to notify us, we will assume you have not corrected.

Also, pursuant to the provisions of IDAPA 16.03.07.003, Access Home Care is being issued a Provisional Home Health license. The license is enclosed and is effective December 3, 2008, through April 3, 2008. The conditions of the Provisional License are as follows:

- 1. Post the provisional license.
- 2. Correct all cited deficiencies and maintain compliance.

Please be aware that failure to comply with the conditions of the provisional license may result in further action being taken against the facility's license pursuant to <u>IDAPA 16.03.07.003</u>.

Chad Mangum December 18, 2008 Page 3 of 3

Be advised, that, consistent with IDAPA 16.05.03.300, you are entitled to request an administrative review regarding the issuance of the provisional license. To be entitled to an administrative review, you must submit a written request by January 15, 2009. The request must state the grounds for the facility's contention of the issuance of the provisional license. You should include any documentation or additional evidence you wish to have reviewed as part of the administrative review. Your written request for administrative review should be addressed to:

Randy May, Deputy Administrator Division of Medicaid -- DHW P.O. Box 83720 Boise, ID 83720-0036

phone: (208)364-1804 fax: (208)364-1811

If you fail to submit a timely request for administrative review, the Department of Health and Welfare's decision to issue the provisional license becomes final. Please note that issues which are not raised at an administrative review may not later be raised at higher level hearings (IDAPA 16.05.03.301).

We urge you to begin correction immediately. If you have any questions regarding this letter or the enclosed reports, please contact me at (208)334-6626.

Sincerely,

SYLVIA CRESWELL

Co-Supervisor

Non-Long Term Care

SC/mlw

Enclosures



190 W. Burnside Ste. E Chubbuck, Idaho 83202 Tel. (208) 637-2273 Fax (208) 637-8867 www.accesshomecareandhospice.com

January 6, 2009

Division of Medicaid -- DHW 3232 Elder Street P.O. Box 83720 Boise, ID 83720-0036

Attention: Sylvia Creswell, Co-Supervisor

Dear Ms. Creswell,

On December 3, 2008, your staff completed a Medicare/Licensure survey at our office in Chubbuck, Idaho. Our office received the official Statement of Deficiencies on December 22, 2008. In response to the Statement of Deficiencies, we have prepared and enclosed a Plan of Correction.

We were grateful to have Gary Guiles and Patrick Hendrickson as our surveyors. Both were professional, informative, and courteous.

If there are any questions regarding the Plan of Correction, please don't hesitate to call me at (208) 637-2273.

Sincerely,

Chad Mangum BSN, RN Clinical Administrator

RECEIVED

JAN - 7 2009

FACILITY STANDARDS

PRINTED: 12/18/2008 FORM APPROVED OMB NO. 0938-0391

			3	ING	(X3) DATE SURVEY COMPLETED	
		137110	B. WING		12/0	3/2008
	PROVIDER OR SUPPLIER  S HOME CARE, LLC	\\\\\\\\	s	TREET ADDRESS, CITY, STATE, ZIP CODE 190 WEST BURNSIDE AVENUE, SUITE I CHUBBUCK, ID 83202		7072000
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPR DEFICIENCY)	ULD BE	(X5) COMPLETION DATE
G 000	INITIAL COMMENT	S	G 000	O	······································	
	recertification surve	encies were cited during the y of your home health agency. g the recertification were:				
	Gary Guiles, RN, HF Patrick Hendrickson					
	Acronyms used in th	is report include:				
G 122	HHA = Home Health NSA = Negotiated S OT = Occupational T PA = Physician Assis POC = Plan of Care PT = Physical Thera RCF = Residential C SN = Skilled Nursing SOC = Start of Care SW = Social Worker 484.14 ORGANIZAT	ervice Agreement Therapy stant by are Facility	G 122	G122-		1/6/2009
	ADMINISTRATION  This CONDITION is Based on staff intervicinical records and a determined the gover systems had been deprovide basic care an coordinate care. The Refer to G133 as it agency to ensure the sufficient organization	not met as evidenced by: ew and review of patients' gency policies, it was ning body failed to ensure veloped and implemented to d services to patients and to findings include:  relates to the failure of the administrator provided and direction to agency		The governing body of Access Ho Care has proper systems in place this day January 6, 2009 to ensur basic care and services are met for patient. This will be evidenced by following plan of corrections that proceed in this document. Governody will be updated on the compof the following plan of correction quarterly basis with quality assurance ting and also as needed or	as of e all or the y the ning pliance	
S	staff to ensure basic s	ervices and processes /SUPPLIER REPRESENTATIVE'S SIGNA	 	requested by the governing body.	<u></u>	(6) DATE

In deficiency statement ending with an asterisk (\*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days ollowing the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 lays following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued rogram participation.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		IDENTIFICATION NUMBER:		LTIPLE CONSTRUCTION		(X3) DATE SURVEY COMPLETED	
			A. BUILI				
		137110	B. WINC		12/	/03/2008	
	F PROVIDER OR SUPPLIER SS HOME CARE, LLC			STREET ADDRESS, CITY, STATE, ZIP CODE 190 WEST BURNSIDE AVENUE, SUITE CHUBBUCK, ID 83202			
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G 123	would be defined ar  2. Refer to G143 as agency to ensure cawith outside entities agency patients.  3. Refer to G158 as agency to ensure Poprivate pay and other 4. Refer to G185 as agency to ensure Orordered.  5. Refer to G334 as agency to ensure cowere completed in a consistent with patients.	it relates to the failure of the are was effectively coordinated that also provided care to it relates to the failure of the DCs were developed for a patients.  it relates to the failure of the F services were provided as it relates to the failure of the mprehensive assessments timely manner and	G 12	2			
G 133	agency practices res to provide consistent 484.14(c) ADMINIST  The administrator, where supervising physician under paragraph (d) of directs the agency's congoing liaison amongroup of professional staff interviews and agency personal the agency failed to entire the provided and agency personal staff interviews and agency personal the agency failed to entire the provided and agency personal staff interviews and agency personal staff interviews and agency personal staff interviews agency failed to entire the provided agency provided agenc	ulted in the agency's inability services to patients. RATOR  no may also be the a or registered nurse required of this section, organizes and ongoing functions; maintains g the governing body, the personnel, and the staff.  not met as evidenced by: ew and review of medical olicies, it was determined insure the administrator panization and direction to	G 133	The administrator will ensure the patients regarding payor source admitted with Medicare standar including a comprehensive assess and development of a plan of case according to Agency's Policy and Procedure #2008. All admitting have been inserviced and will be compliant January 6, 2009. (attack, Agency's Policy and Procedure Assessment/Plan of Care). This	will be rds, ssment are d staff e chment e #2008	1/6/2009	

# DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES (X1) PROVIDER/SURPLIER/CLIA

AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MU A. BUILI	LTIPLE CONSTRUCTION DING		(X3) DATE SURVEY COMPLETED	
	- 11	137110	B. WING	)	12/	03/2008	
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	processes would be agency, through the ensure that system patients were compsystems were in place to direct staff systems were in place to agency patiently place to ensure occurred were available to all affected the care of #5, #7, #8, #10, and reviewed. The finding of the comprehensive assepatients. Refer to Gassessments for private place for private pay 3. The administrator had been developed plans to direct the care for private pay 3. The administrator had been developed effectively coordinated effectively effectively coordinated effectively effecti	defined and provided. The administrator, failed to so were in place to ensure prehensively assessed, that ace to ensure patients had in the provision of care, that ace to ensure care was her providers who furnished ents, and that systems were in upational therapy services patients. These omissions 8 of 15 patients (#1, #3, #4, #14) whose care was her provide:  Thad not ensured a system and implemented to provide essments to private pay 334 as it relates to the lack of vate pay and other patients.  Thad not ensured a system and implemented to develop are provided to patients.  That not ensured a system and implemented to patients.  That not ensured a system and implemented to care with outside entities. The patients and other patients.  That not ensured a system and implemented to be care with outside entities. The patients are with outside entities.  The patients are provided to patients.  The patients are provided to a system and implemented to be care with outside entities. The patients are patients.  The patients are provided to patients.  The patients are provided to a system and implemented to be care with outside entities. The patients are patients.  The patients are provided to provided to patients.  The patients are patients are provided to patients.  The patients are provided to provided to patients.  The patients are provided to provided to provided to patients.	G 13	ensured by an audit completed hours after the completed a Registered Nurse. Weekl will be completed by a Region patients following admicompliance to the plan of care patients chart will be audit minimum of bi-monthly to compliance to plan of care administrator will ensure the audits are being completed monthly IDT's are being he coordinate cares.	ted admit by y chart audits gistered Nurse it to ensure care. Each ed at a ensure . The hat the I and bi- Id to		

	NT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA	(X2) N	//ULT	TPLE CONSTRUCTION	1	O. 0936-039 SURVEY
AND LA	OF CONTROLOGY	IDENTIFICATION NUMBER:	A. BU	ILDII	NG	COMF	PLETED
		137110	B. WI	NG_		12	/03/2008
NAME OF	PROVIDER OR SUPPLIER		-,-	ST	REET ADDRESS, CITY, STATE, ZIP CODE	1	70072000
ACCES	S HOME CARE, LLC			1	190 WEST BURNSIDE AVENUE, SUITE E	Ξ	
(X4) ID	SUMMARY STA	TEMENT OF DEFICIENCIES	1 15	<u>, '</u>	CHUBBUCK, ID 83202		
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G 143   484.14(g) COORI SERVICES		NATION OF PATIENT	G ·	143			1/6/2009
	All personnel furnish	ning services maintain liaison			The administrator will ensure the		
	to ensure that their efforts are coordinated				patients receive care according t		
	effectively and support the plan of care.	ort the objectives outlined in			initial home health orders and pl		
the plan of care.					are, and that all services are being		
	This OTANDADD :				coordinated effectively with all t		
	Based on staff interv	not met as evidenced by: iew and review of clinical			involved in the patients care. Ag	•	
	records and agency policies, it was determined the agency failed to ensure care was effectively coordinated with RCF's that also provided care to				will also coordinate all services b		
					provided including therapy service		
	2 of 2 agency patient	s (#3 and #4). Further, it			with the facility in which the pati		
	was determined the	agency failed to ensure care			residing. The facilities will have a		
	was effectively coord	inated with OT and/or SW tients (#1, #7, and #10) who		***************************************	to the appropriate documentatio		
	received OT and/or S	SW services. This prevented		- 1	allow coordination of care, include		
	agency and facility st	aff from working together to		7	the plan of care, verbal orders, da	-	
	include:	patients. The findings		1	clinical notes, and other documen		
	4 12 4 4 4				deemed necessary to the coordin		
	1. Patient #4 was a 6	9 year old female with iabetes and chronic kidney			of care. This will be done accordi Agency's policy #2030. Agency's		
	disease. Her SOC wa	as 11/19/08. Agency		3	has been inserviced and are comp		
	nursing notes docume	ented she was being seen		- 1	as of January 6, 2009. (attachmen		
	of coordination of care	injections. Documentation between the agency and		1	Agency's Policy and Procedure #2		
	an RCF where the pair	tient lived was not present in		- 1	Coordination of Services) Agency		1.
	the patient record. The	ne Patient Care Coordinator, 3 at 9:50 AM, confirmed		i	delegated representative from the		
	there was no docume	ntation of care			administrator will follow up bi-mo		`
	coordination. A visit w	/as made to the RCF on			will all facilities where agency is se		
	interviewed. The nurs	12/3/08 at 8:15 AM and the facility nurse was interviewed. The nurse stated agency staff had			patients. Agency's representative		
	not provided the RCF	with a copy of the patient's			audit the facility chart for the pres		
	POC or other written information regarding the patient's care. The nurse stated the RCF had				of signed plan of care, updated or		
	requested this informa	tion from the agency but it			ned sheets, coordination of care		
		3-11-91					

		IDENTIFICATION NUMBER:		X2) MULTIPLE CONSTRUCTION  A. BUILDING			(X3) DATE SURVEY COMPLETED	
		137110	B. WIN	IG		12/0	03/2008	
	PROVIDER OR SUPPLIER SS HOME CARE, LLC			19	EET ADDRESS, CITY, STATE, ZIP CODE 90 WEST BURNSIDE AVENUE, SUITE I HUBBUCK, ID 83202			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPE DEFICIENCY)	ULD BE	(X5) COMPLETION DATE	
G 14	2. Patient #3 was a SOC date of 11/24/ on 12/02/08. She whealth agency for mright foot cellulitis. 11/24/08, stated the and the agency's nutimes a week. The services 2 times a w RCF on 12/2/08 at 9 record was reviewed contain any docume of care. The RCF's was receiving home and did not docume On 12/2/08 at 9:40 / stated that she had RCF's nurse nor did policy which outlined care with facilities will present in the policy Coordinator, intervie AM, stated the agen addressed coordinate entities such as RCF coordinate services where she was found displaced femoral neight hemiarthroplast patient was discharge on 3/6/08. A nursing stated the agency was state	90-year-old female with a 08, and was a current patient vas admitted to the home onitoring and treatment of The patient's POC, dated patient resided in an RCF tree was seeing the patient 2 patient was also receiving PT veek. During a visit to the 0:00 AM, the patient's RCF d. The patient's record did not ented evidence of coordination NSA did not state the patient health services and cares int coordination of services. AM, the home health nurse not met or talked with the she know her name. A I how staff were to coordinate there patients lived was not manual. The Patient Care wed on 12/10/08 at 11:15 cy did not have a policy which ion of care with outside 5. The agency failed to	G 1	43	with the facility, that staff is coordinating cares with the facility policy #2030 is being followed. compliance is found the agency representative will notify the administrator for follow up to not compliance.	If non-		

AND PLAN OF CORRECTION	IDENTIFICATION NUMBER:		LDING	= CONSTRUCTION	COMPLETED	
	137110	B. Wil	1G	9.50	12/	03/2008
NAME OF PROVIDER OR SUPPLIER  ACCESS HOME CARE, LLC		•	190	T ADDRESS, CITY, STATE, ZIP CODE WEST BURNSIDE AVENUE, SUITE JBBUCK, ID 83202		
PRÉFIX (EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRE (EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE APP DEFICIENCY)	IOULD BE	(X5) COMPLETION DATE
"Occupational Ther contain documente had provided an OT to the patient. On the Administrator confir received an OT evaluated that the ager OT services in outly to coordinate service received an OT evaluation of the patient #7 was a SOC date of 11/24/2 as of 12/3/08. She health agency follow 11/11/08. The patient physician's order datagency to provide "Coupational There replacement." As of received an OT evaluation of the physical the patient, (on 11/24/08 would not benefit from confirmed the patient evaluation or treatment coordinate services from OT evaluation or treatment of the patient was a solution of the patient was	resting the agency to provide apy." The record did not devidence that the agency revaluation or OT treatment (12/2/08 at 1:23 PM, the Clinical med the patient had not aluation and/or treatment. He acy was having trouble getting ring towns. The agency failed es to insure the patient luation or treatment.  71-year-old female with a 108, and was a current patient was admitted to the home wing a left hip surgery on ant's record contained a ted 11/19/08, requesting the Decupational Therapy." On order, by a second physician attent to receive apy for rehabilitation of hip for 12/03/08, the patient had not uation and/or treatment. On the Clinical Administrator merapist had assessed the sty, and decided the patient mother of services. He thad not received an OT tent. The agency failed to be insure the patient received at treatment.  190-year-old female with a 190-year-old female wi	G	43			

		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION  A. BUILDING			(X3) DATE SURVEY COMPLETED	
		137110	B. WI	1G		12/0	03/2008	
	PROVIDER OR SUPPLIER S HOME CARE, LLC			1	REET ADDRESS, CITY, STATE, ZIP CODE 90 WEST BURNSIDE AVENUE, SUITE E CHUBBUCK, ID 83202			
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G 143	9/23/08, stated the several times a day toileting, transferring meals, housekeepir record contained a dated, requesting the "Occupational There contain documented received an OT evaluation. The recording the patient evaluation. The recommentation that the referral. The age services and the patient evaluation and/or tree. Further, Patient #10' 9/23/08, stated the patient's record contidated 9/23/08, reques to work the referral occumented evidence of the provided a SW consult.	patient needed "assistance" with bathing, dressing, g, ambulation, medications, ng, and laundry. The patient's ohysician's order that was not be agency to provide apy." The record did not dievidence that she had fluation and/or OT treatment. PM, the Clinical Administrator and had not received an OT ord did not contain the OT had been notified of ency failed to coordinate itent did not receive an OT eatment.  Is nursing assessment dated attent was depressed. The ained a physician's order, esting the agency to provide a cord did not contain that the patient was ult. On 12/2/08 at 3:57 PM, rator confirmed the patient	G	43				
G 156	was interviewed. Sh were held weekly but meetings. She state get their notes in it ca coordination. She rerecord. She stated the checks and balance a coordination of services.	viewed Patient #7s and #10s ne agency needed a better process for OT referrals and	G 15	6				

NAME OF PROVIDER OR SUPPLIER  B. WING  12/03/20  STREET ADDRESS, CITY, STATE, ZIP CODE	208
NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE	
ACCESS HOME CARE, LLC  190 WEST BURNSIDE AVENUE, SUITE E CHUBBUCK, ID 83202	
	(X5) MPLETION DATE
G 156 Continued From page 7 G 156 G 156/G158 1/6	5/2009
This CONDITION is not met as evidenced by: Based on staff interview and review of patients' clinical records and agency policies, it was determined the agency failed to ensure systems had been developed and implemented to plan for patients' care. The findings include:  Refer to G158 as it relates to the failure of the agency to ensure POCs were developed for private pay and other patients. The cumulative effect of these negative systemic facility practices resulted in the agency's inability provide direction to staff who were caring for patients.  G 158 484.18 ACCEPTANCE OF PATIENTS, POC, MED SUPER  Care follows a written plan of care established and periodically reviewed by a doctor of medicine, osteopathy, or podiatric medicine.  This STANDARD is not met as evidenced by: Based on staff interview and review of medical records and agency policies, it was determined the agency failed to develop, implement, and/or provide services consistent with the POCs for 2 of 3 private pay patients; (#1, 38 4, 48, 7, #10, and #15) whose records were reviewed. This resulted in the inability of the agency to ensure care was provided in a systematic manner. The findings include:  1. Patient #8 was a 14 year old male who was admitted following hospitalization for treatment of injuries received in a motor vehicle accident.	/2009

STATEMEN AND PLAN (	TATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		1` '	MULTIPLE CONSTRUCTION UILDING		(X3) DATE SURVEY COMPLETED	
,		137110	B. WIN	1G _		12	/03/2008
	PROVIDER OR SUPPLIER  HOME CARE, LLC			1	REET ADDRESS, CITY, STATE, ZIP CODE 90 WEST BURNSIDE AVENUE, SUITE E CHUBBUCK, ID 83202		00,200
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	These injuries includinternal injuries. His 12/2/08, he did not he The Clinical Administration at 11:30 AM, stated patient. The administration not normally develop patients.  2. Patient #14 was a date of 10/21/08. He health agency follow was involved in an a inpatient consultation documented the patilower extremity which as skin injuries. The that, while receiving patient was seen at a treatment of his skin in place. The patient 12/2/08. The patient 12/2/08. The patient POC. On 12/3/08 at Administrator reviewed a POC had said it was not a norm POC for private pay patient #3 was a 9/3/3/3 Patient #3 was a 9/3/3 Patient #3 wa	ded several fractures and s SOC was 10/31/08. As of nave a comprehensive POC. strator, interviewed on 12/2/08 the patient was a private pay strator said agency staff did o POCs for private pay staff did o POCs for priva	G 1	58	monthly to ensure compliance to of care. The administrator will e that the audits are being comple bi-monthly IDT's are being held to coordinate cares.	nsure ted and	
_   a	iocumented that the a	agency had not developed a					

	OF CORRECTION	IDENTIFICATION NUMBER:	A. BU		NG	COMPI	
		137110	B. WII	۷G		12/	03/2008
	PROVIDER OR SUPPLIER  S HOME CARE, LLC			1	REET ADDRESS, CITY, STATE, ZIP CODE 190 WEST BURNSIDE AVENUE, SUITE CHUBBUCK, ID 83202		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTION  (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		(X5) COMPLETION DATE
	POC for Patient #3. contain physician's services. The recorwritten by a PA, date Evaluation". This with the RN assigne 9:00 AM. The agen a POC.  4. Patient #4 was a diagnoses of type II disease. Her SOC odocumented she wainsulin injections. As SOC, a POC had no staff. The Director of 12/1/08 at 3:15 PM, completed because the Thanksgiving ho 5. Patient #5 was and diagnoses of joint pawas 9/24/08. Her not 11/23/08. Her POC 12/1/08, 8 days after started. The Clinical on 12/2/08 at 10:30 / been completed until 6. Patient #7 was a 7 SOC date of 11/24/0 as of 12/02/08. She health agency followi 11/11/08. The patier mellitus, pernicious a surgery. She had be therapy after her surgery.	Further, the record did not orders for nursing and PT of only contained an order ed 11/22/08, for a "Home was confirmed by interview ed to the patient, on 12/2/08 at cy failed to develop and follow 69 year old female with diabetes and chronic kidney was 11/19/08. Nursing notes as being seen twice a day for so of 12/1/08, 12 days after the of been developed by agency of Home Care, interviewed on stated the POC had not been staff had been too busy over liday.  88 year old female with an and dementia. Her SOC ew certification period started was not completed until the certification period Administrator, interviewed AM, stated the POC had not 12/1/08.  71-year-old female with a 8. She was a current patient was admitted to the homeing a left hip surgery on thad a history of diabetes anemia, hypertension, back en started on anticoagulation gery. The physician ordered and PT services on 11/19/08.	G ·	158			

AND PLAN OF CORRECTION		IDENTIFICATION NUMBER:	A. BUI		VG	COMPLETED	
		137110	B. WIN	1G _		12/0	3/2008
	PROVIDER OR SUPPLIER  S HOME CARE, LLC			1	REET ADDRESS, CITY, STATE, ZIP CODE 190 WEST BURNSIDE AVENUE, SUITE E CHUBBUCK, ID 83202		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPR DEFICIENCY)	ULD BE	(X5) COMPLETION DATE
	11/24/08, stated the several times a day toileting, medication laundry. The patient that needed monito record documented developed a POC for 10:30 AM, the Clinic patient's POC had in holiday and the fact several of new patient. The agency main BOOK" for tracking physicians. The log between 10/3/08 and Manager maintained documented 10 plar developed until betw SOC or certification confirmed this during 10:00 AM.  8. Patient #1 was a SOC date of 2/1/08. home health agency a minimally displace underwent a right hip discharged from the The patient's POC, owould see the patient weeks. The patient 2/8/08, and was not 2/29/08. The process during the 2 service. The record evidence that the age physician of the missing the missing the missing the missing physician of the missing the missing physician of the missing physician physician of the missing physician phy	e patient needed "assistance" with bathing, dressing, as, meals, housekeeping and a surgical wound ring. Review of the patient's that the agency had not be patient #7. On 12/3/08 at cal Administrator stated the not been developed due to the that the agency had admitted ents during that past week.	G 1	58			

# DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES (X1) PROVIDER/SUPPLIER/CLIA

AND PLAN OF CORRECTION		IDENTIFICATION NUMBER:	A. BU		NG	COMPLETED	
		137110	B. Wil	√G_		12/	03/2008
	PROVIDER OR SUPPLIER  S HOME CARE, LLC			1	REET ADDRESS, CITY, STATE, ZIP CODE 190 WEST BURNSIDE AVENUE, SUITI CHUBBUCK, ID 83202	-	
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRI (EACH CORRECTIVE ACTION SI CROSS-REFERENCED TO THE AP DEFICIENCY)	ACTION SHOULD BE CO TO THE APPROPRIATE	
	missed visits. She notified. She said it to notify physicians agency provided few physician had order altered the POC amphysician.  9. Patient #10 was a SOC date of 9/23/011/13/08. She was agency due to being assessment dated 9 needed "assistance bathing, dressing, to ambulation, medical and laundry. The pastated the HHA wou week for six weeks. HHA on 9/27/08 and HHA until 10/20/08. HHA services during week of service. Ad patient on 11/10/08, service. The agency order for aide service not contain documen notified the physician On 12/2/08 at 3:57 Foonfirmed the physician or missed visits fewer and extra visits ordered and therefor POC without notifyin nursing assessment patient was depressed contained a physician requesting the agency	stated the physician was not was not the agency's practice of patient missed visits. The wer visits than what the ed and therefore, the agency d should have notified the a 90-year-old female with a last She was discharged on admitted to the home health a high fall risk. The nursing 0/23/08, stated the patient several times a day" with	G	158			

	T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) M A. BUI		IPLE CONSTRUCTION	(X3) DATE S	
		137110	B. WIN	1G	······	12/0	03/2008
	PROVIDER OR SUPPLIER  HOME CARE, LLC			1	REET ADDRESS, CITY, STATE, ZIP CODE 90 WEST BURNSIDE AVENUE, SUITE E CHUBBUCK, ID 83202		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES 'MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTIVE ACTION SHOUNDS OF THE APPR DEFICIENCY)	ULD BE	(X5) COMPLETION DATE
G 158	patient was provide On 12/2/08 at 3:57 confirmed the patie consult. 10. Patient #15 was SOC date of 10/15/	d a social worker's consult. PM, the Clinical Administrator nt had not received an SW an 80-year-old male with a 08. He was a current patient	G 1	58			
G 185	health agency due to weakness. The pattern stated the HHA would a week for six week patient was seen by was not seen again did not receive HHA of service. The recodocumentation that physician of the mis PM, the Clinical Admitted physician was not in The agency provided physician ordered, the	the agency had notified the sed visit. On 12/2/08 at 1:10 ninistrator confirmed the formed of the missed visit. If the fewer visits than the herefore the agency altered have notified the physician.	G 1	85	G 185-		1/6/2009
	or under arrangeme therapist or by a qua	s offered by the HHA directly nt are given by a qualified diffied therapy assistant under qualified therapist and in plan of care.			The administrator will ensure the ordered disciplines including the and social services will be started the appropriate time frame and coordinated according to Policy	erapy d within	
	Based on review of c interview, it was dete ensure therapy servi- ordered by the physic patients, who had ordered	not met as evidenced by: clinical records and staff ermined the agency failed to ces were provided as cian for 3 of 4 sampled ders to receive OT services his resulted in omitted		***************************************	Procedure #2030 (coordination of services). All appropriate staff has been inserviced on this policy ar compliant as of January 6, 2008. appropriate staff have been inserviced on these policy and procedures.	nave nd are . All erviced	

 T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MI A. BUIL		PLE CONSTRUCTION  G	(X3) DATE S COMPLE	
	137110	B. WIN	G	daylaha, dahla lamata, lamata, dahla d	12/0	3/2008
(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI) TAG	19 C	EET ADDRESS, CITY, STATE, ZIP CODE  O WEST BURNSIDE AVENUE, SUITE E  HUBBUCK, ID 83202  PROVIDER'S PLAN OF CORRECT  (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPRINCIPLE OF THE APPRINCIPLE O	TION JLD BE	(X5) COMPLETION DATE
evaluations and treatindings include:  1. Patient #1 was a SOC date of 2/1/08, home health agency a minimally displace underwent a right hid discharged from the A "Intake/Referral" if a nurse stated, the a OT services to imprimprove her gait and patient's POC dated received assistance living from a "couple at home" and the agrecord contained a provided an OT to the patient. On 12 Administrator confirmed and provided an OT to the patient. On 12 Administrator confirmed and provided an OT to the patient. On 12 Administrator confirmed and providing OT service patient did not received that the agree providing OT service patient did not received an OT service patient did not received and other treatment per physical social physician had not be he stated that the agree providing OT service patient did not received and other treatment per physical social physician had not be he stated that the agree physical physician had not be he stated that the agree physical physician had not be he stated that the agree physical physician had not be he stated that the agree physical physician had not be he stated that the agree physical physician had not be he stated that the agree physical physician had not be he stated that the agree physical p	66-year-old female with a She was admitted to the following a hospitalization for a femoral neck fracture and p surgery. The patient was agency's service on 3/6/08. Form, dated 2/1/08, written by agency was to provide PT and ove strength, mobility and drange of motion. The 2/1/08, stated the patient with her activities of daily who came in and helped her ency's HHA. The patient's obysician's order dated the agency to provide app." The record did not evidence that the agency evaluation or OT treatment 2/2/08 at 1:23 PM, the Clinical ned the patient had not uation or treatment and the ten notified of this. Further, ency was having trouble is in outlying towns. The re an OT evaluation and/or	G 1	85	compliant as of January 6, 2009 will be ensured by an audit comwithin 48 hours after the compladmit by a Registered Nurse. We chart audits will be completed by Registered Nurse on all patients following admit to ensure compto the plan of care. Each patien will be audited at a minimum of monthly to ensure compliance to of care. The administrator will eath at the audits are being complete bi-monthly IDT's are being held coordinate cares.	eekly oy a siliance ts chart o plan ensure	

	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	' '	IULTIPL ILDING	E CONSTRUCTION		E SURVEY PLETED
		137110	B, Wil	4G		1:	2/03/2008
	PROVIDER OR SUPPLIER S HOME CARE, LLC			190	ET ADDRESS, CITY, STATE, ZIP CO WEST BURNSIDE AVENUE, SU UBBUCK, ID 83202		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES 'MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	N SHOULD BE	(X5) COMPLETION DATE
G 185	laundry. The patier physician's order da agency to provide "12/2/08, a second of was written for the proceed an OT evaluation and/orders.  3. Patient #10 was SOC date of 9/23/0 11/13/08. She was agency due to being fatigue, weakness, ordered to be several times a day" toileting, transferring meals, housekeeping record contained a pdated, requesting the "Occupational Thera contain documentation that the OT evaluation and/orders.	at's record contained a lated 11/19/08, requesting the Occupational Therapy." On order, by a different physician patient to receive apy for rehabilitation of hip of 12/03/08, the patient had not luation and/or treatment. On the Clinical Administrator therapist had assessed the and decided the patient would services. He confirmed the lived an OT evaluation or the physician had not been patient did not received an or treatment per physicians'  a 90-year-old female with a late of the home health a high fall risk, increased late of the home health a high fall risk, increased late of the home health a high fall risk, increased late of the home health a high fall risk, increased late of late of the home health and high fall risk, increased late of late o	G	185			

	T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) Mt A. BUIL		PLE CONSTRUCTION  G	(X3) DATE S COMPL	
		137110	B. WIN	G_		12/0	3/2008
	PROVIDER OR SUPPLIER  HOME CARE, LLC			19	EET ADDRESS, CITY, STATE, ZIP CODE 90 WEST BURNSIDE AVENUE, SUITE E HUBBUCK, ID 83202		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	x	PROVIDER'S PLAN OF CORREC' (EACH CORRECTIVE ACTION SHOI CROSS-REFERENCED TO THE APPR DEFICIENCY)	JLD BE	(X5) COMPLETION DATE
G 185		ge 15 ation and/or treatment per	G 1	85			
G 228	If the patient receive registered nurse mu	es skilled nursing care, the set perform the supervisory	G 22		G 228- The administrator will ensure that aide supervisory visits will be do		1/6/2009
	If the patient is not re but is receiving anot physical therapy, oc speech-language pa	agraph (d)(2) of this section. eceiving skilled nursing care, her skilled service (that is, cupational therapy, or ithology services), provided by the appropriate			the appropriate supervisor eithe Registered Nurse or a Physical Therapist, at least every 14 days supervising staff have been inser on this and are compliant as of t	r a . All viced his day	
	Based on staff intervercords and agency that, the agency failed physical therapists he patients' homes no le weeks, for 5 of 8 sand #10 and #15) who reservices. This preverensuring HHAs provito patients. The finding 1. Patient #1 was a 6 SOC date of 2/1/08. Home health agency when she was found displaced femoral nemip surgery. The pating surgery. The pating surgery is service on 3 dated 2/1/08, stated to patient 1-2 times a we patient also received	6-year-old female with a She was admitted to the following a hospitalization		1 1 1 6 6 6 1	January 6, 2008. (see attached prand procedure #8047 Exhibit E) chart audits will be completed by Registered Nurse on all patients following admit to ensure complite to the plan of care. Each patients will be audited at a minimum of I monthly to ensure compliance to of care and supervisory visits. The administrator will ensure that the audits are being completed and be monthly IDT's are being held to coordinate cares.	Weekly ance s chart oi- plan e	

	T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) M A. BUI		TIPLE CONSTRUCTION NG	(X3) DATE S COMPL	
		137110	B. WI	√G		12/0	03/2008
	PROVIDER OR SUPPLIER  S HOME CARE, LLC			1	REET ADDRESS, CITY, STATE, ZIP CODE 190 WEST BURNSIDE AVENUE, SUITE CHUBBUCK, ID 83202	E	
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES  MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APP DEFICIENCY)	OULD BE	(X5) COMPLETION DATE
	patient was seen by 2/29/08. The record documentation that supervisory HHA vis On 12/2/08 at 1:23 confirmed that the F supervisory HHA vis agency's policy for I dated or titled. Pagisupervisory visits was not followed.  2. Patient #9 was ar date of 7/22/08. He health agency follow myocardial infarction patient as of 12/2/08, 7/22/08, stated the I times a week for nin services were discord service. The patient nursing services 1 to PT was also to see to week for 9 weeks. The patient and 8/26/08. The documentation that in the necessary supersix weeks of HHA's see PM, the Clinical Admisupervisory visits had 3. Patient #10 was a SOC date of 9/23/08 11/13/08. She was a agency due to being fatigue, weakness, Confusion. The nursing services agency due to being fatigue, weakness, Confusion. The nursing fatigue, The nursin	of the HHA on 2/5, 2/7 and did not contain PT staff had made a sit during her time of services. PM, the Clinical Administrator PT had not made a sit to the patient's home. The HHA supervision was not e 69 stated, "Make every two weeks" This policy in 86-year-old male with a SOC was admitted to the home ving a hospitalization for a normal management. The patient was a current and the patient six weeks of the weeks. However, HHA intinued after six weeks of the patient 2 to 3 times a week for 3 weeks. The patient was seen by the solid patient was solid patien	G 2	228			

# DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES (X4) PROVIDER/SUBBLIED/CLIA

	T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) M A. BU		TIPLE CONSTRUCTION	(X3) DATE S COMPL	
		137110	B. Wil	۷G _		12/0	03/2008
	PROVIDER OR SUPPLIER  HOME CARE, LLC			1	REET ADDRESS, CITY, STATE, ZIP CODE 190 WEST BURNSIDE AVENUE, SUITE CHUBBUCK, ID 83202	: <b>E</b>	
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES 'MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRE (EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE APF DEFICIENCY)	OULD BE	(X5) COMPLETION DATE
	several times a day toileting, transferring meals, housekeepin POC, dated 9/23/08 the patient was also receivities. The patie 9/27, 10/20, 10/27 and contain docume made supervisory PM, the Clinical Adriurse had not made the patient's home.  4. Patient #15 was a SOC date of 10/15/during the time of the the home health aga confusion and weak dated 10/16/08, stat patient 2 to 3 times and 10/19/08. The paskilled nursing service the HHA on 10/19, 11/7, 11/11, 11/14	"with bathing, dressing, g, ambulation, medications, ng, and laundry. The patient's is, stated the HHA would see week for six weeks. The seiving skilled nursing int was seen by the HHA on and 11/10/08. The record did intation that nursing staff had ill-indicated that the experience that the experience that the experience that the experience that increased in 80-year-old male with a 108, and was a current patient in experience that was also receiving the experience of the HHA would see the experience was also receiving the experience of the patient was seen by 10/21, 10/24, 10/28, 10/31, 11/18 and 11/23/08. The in documented evidence that inde supervisory HHA visits. The indicated had not made the patient's home.  88 year old female with in and dementia. Her SOC	G	228			

	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MUL A. BUILD	TIPLE CONSTRUCTION ING	(X3) DATE : COMPL	
		137110	B. WING		12/	03/2008
	PROVIDER OR SUPPLIER  S HOME CARE, LLC			REET ADDRESS, CITY, STATE, ZIP CODE 190 WEST BURNSIDE AVENUE, SUITE CHUBBUCK, ID 83202	E	•
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES  MUST BE PRECEDED BY FULL  SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APP DEFICIENCY)	OULD BE	(X5) COMPLETION DATE
	that time, no supervalues or a physical The Patient Care C 12/2/08 at 9:30 AM, stated the supervised documented. 484.55(b)(1) COMP COMPREHENSIVE The comprehensive completed in a time patient's immediate calendar days after. This STANDARD is Based on staff intervecords and agency the agency failed to assessment was conconsistent with the p2 of 3 sampled patiential private pay patients. to ensure a comprehensive completed for 1 of 1 complex teaching nearly from ensuring all of the planned for. The fine 1. Patient #8 was a admitted following he injuries received in a These injuries resulted including fractures of internal injuries. His written "SN Start of C 1.60" form, dated 10 record. This served	visory visits by a registered therapist were documented. coordinator, interviewed on reviewed the record and bry visits were not or visits with the needs, but no later than 5 the start of care.  In our met as evidenced by: view and review of medical policies, it was determined ensure a comprehensive mpleted in a timely manner, visitent's immediate needs, for onts (#8 and #14), who were on addition, the agency failed nensive assessment was other patient (#4) with or visits of the patients' needs were dings include:  If year old male who was obspitalization for treatment of motor vehicle accident, and in multiple fractures, or the left arm and leg, and sooc was 10/31/08. A hand care/Resumption of Care (31/08, was included in the last the comprehensive	G 228	The administrator will ensure the patients regarding payor source admitted with Medicare standard including a comprehensive assess and development of a plan of cast according to Agency's Policy and Procedure #2008. All admitting have been inserviced and are cost as of this day January 6, 2009. (attachment A, Agency's Policy and Procedure #2008 Assessment/Pl Care) All appropriate staff have inserviced on these policy and procedures and are compliant as January 6, 2009. This will be ensure an audit completed within 48 hou after the completed admit by a Registered Nurse. Weekly chart will be completed by a Registered on all patients following admit to ensure compliance to the plan of	will be rds, ssment are d staff impliant and lan of been s of sured by ours audits ed Nurse of f care.	1/6/2009
		sessment was not signed. s not complete. The Patient		Each patients chart will be audite minimum of bi-monthly to ensur		-

	T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) ML A. BUIL	JLTIPLE CONSTRUCTION DING	(X3) DATE S COMPL	
		137110	B. WIN	G	12/0	03/2008
	PROVIDER OR SUPPLIER  S HOME CARE, LLC			STREET ADDRESS, CITY, STATE, ZIP 190 WEST BURNSIDE AVENUE, CHUBBUCK, ID 83202	CODE	
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO T DEFICIENC	TON SHOULD BE THE APPROPRIATE	(X5) COMPLETION DATE
	Care Coordinator, in AM, stated at least of were incarcerated a other parent. The P the patient lived with was working to obta The Clinical Adminishad legal guardians information was not The assessment stamember" took "lead managing the patient did not state if that pall times or whether assistance. The Patithe patient did not at injuries. The patient services were not as made by the surveyor The patient lived in a stairs in front and nathe garage. The patiwhen he was admitted was ambulating with He was sleeping in a room but he stated hinto a room over the go down stairs into the very narrow steep wor floor over the garage half way down the stated hinto a room over the garage half way down the state environment was also confirmed by intervier Coordinator, on 12/10.  2. Patient #14 was a date of 10/21/08. He nealth agency following	nterviewed on 12/10/08 at 9:00 one of Patient #8's parents and he had run away from the latient Care Coordinator said in his aunt. She said the aunt in custody of the minor child. Strator was not sure if the aunt hip of the patient or not. This included in the assessment. It ted an "Other family responsibility for providing or it's care" The assessment erson was with the patient at the patient needed such itent Care Coordinator stated tend school due to his it's educational status and sessed. A home visit was or on 12/2/08 at 1:00 PM. In house with several steep rrow winding stairs leading to fent was non-weight bearing ed. At the time of the visit he a walker with supervision. hospital bed in the living e was anxious to move back garage. This required him to be garage and then climb soden stairs to the second. A hand rail extended only airs. An assessment of the onot documented. This was we with the Patient Care	G 33	monthly IDT's are being I coordinate cares. compliance to plan of car administrator will ensure audits are being complete.	e. The that the	

	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) N A. BUI		IPLE CONSTRUCTION IG	(X3) DATE S COMPLI	
		137110	B. WI	√G		12/0	3/2008
	PROVIDER OR SUPPLIER S HOME CARE, LLC			19	REET ADDRESS, CITY, STATE, ZIP CODE 90 WEST BURNSIDE AVENUE, SUITE I CHUBBUCK, ID 83202	Ē	
(X4) ID PREFIX TAG	(EACH DEFICIENCY	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPF DEFICIENCY)	ULD BE	(X5) COMPLETION DATE
	injuries to his right le fractures as well as a current patient as assessment had no 12/3/08 at 1:20 PM, reviewed the patient assessment was co a normal practice to assessment for privagency's policy for cwas not dated or title visit shall be made twho will perform the assessment" This 3. Patient #4 was a diagnoses of type II disease. Her SOC vidocumented she wainsulin injections. The was interviewed on stated the goal of the patient to self admin Care Coordinator sabeen under the care agency that had bee the patient to self ad the patient care Conot been evaluated to capable of learning the example, the agency or not the patient had visual acuity necessal patient resided in an determined what help	dower extremity, including skin injuries. The patient was of 12/3/08. A comprehensive of been documented. On the Clinical Administrator of the confirmed not ompleted and stated it was not of do a comprehensive vate pay patients. The comprehensive assessments led. Page 54 stated, "An initial by a Licensed Professional"	G	334			

STATEMEN AND PLAN	T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) M A. BU		PLE CONSTRUCTION		(X3) DATE S COMPLI	URVEY ETED
		137110	B. Wil	vG			12/0	3/2008
	ROVIDER OR SUPPLIER			19	EET ADDRESS, CITY, STATE, ZIP ( 0 WEST BURNSIDE AVENUE, S HUBBUCK, ID 83202			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF C (EACH CORRECTIVE ACTIV CROSS-REFERENCED TO TH DEFICIENCY	ON SHOU 1E APPRO	LD BE	(X5) COMPLETION DATE
G 334	assist the patient to levels. This preven	ner the facility was willing to monitor her blood glucose ted the agency from teach the patient to self	G	334	•			
	·							
The second secon				ALALALALALALA, erretereren Malamald, erreterera Malamald, erretere			***************************************	

FORM APPROVED Bureau of Facility Standards STATEMENT OF DEFICIENCIES (X3) DATE SURVEY (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION AND PLAN OF CORRECTION COMPLETED IDENTIFICATION NUMBER: A. BUILDING B. WING 137110 12/03/2008 STREET ADDRESS, CITY, STATE, ZIP CODE NAME OF PROVIDER OR SUPPLIER 190 WEST BURNSIDE AVENUE, SUITE E ACCESS HOME CARE, LLC CHUBBUCK, ID 83202 SUMMARY STATEMENT OF DEFICIENCIES (X4) ID PROVIDER'S PLAN OF CORRECTION PRÉFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX (EACH CORRECTIVE ACTION SHOULD BE COMPLETE CROSS-REFERENCED TO THE APPROPRIATE TAG REGULATORY OR LSC IDENTIFYING INFORMATION) DATE TAG DEFICIENCY) N 000 16.03.07 INITIAL COMMENTS N 000 The following deficiencies were cited during the Idaho state licensure survey of your home health agency. Surveyors conducting the licensure review were: Gary Guiles, RN, HFS, Team Leader Patrick Hendrickson, RN, HFS Acronyms used in this report include: CVA = cerebrovascular accident (stroke) HHA = Home Health Aide NSA = Negotiated Service Agreement OT = Occupational Therapy PA = Physician Assistant POC = Plan of Care PT = Physical Therapy RCF = Residential Care Facility SN = Skilled Nursing SOC = Start of Care SW = Social Worker 03.07020.01, ADMIN, GOV, BODY N 001 N001-1/6/2009 020. ADMINISTRATION - GOVERNING The governing body of Access Home BODY. Care has proper systems in place as of N001 01. Scope. The home health this day January 6, 2009 to ensure all agency shall be organized under a basic care and services are met for the governing body, which shall assume full legal responsibility for the patient. This will be evidenced by the conduct of the agency. following plan of corrections that

Bureau of Facility Standards

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

Based on staff interview and review of patients' clinical records and agency policies, it was determined the governing body failed to ensure systems had been developed and implemented

Director

proceed in this document.

This Rule is not met as evidenced by:

umpa, NHA TITLE

FORM APPROVED Bureau of Facility Standards STATEMENT OF DEFICIENCIES (X3) DATE SURVEY (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION AND PLAN OF CORRECTION COMPLETED **IDENTIFICATION NUMBER:** A. BUILDING B. WING\_ 137110 12/03/2008 STREET ADDRESS, CITY, STATE, ZIP CODE NAME OF PROVIDER OR SUPPLIER 190 WEST BURNSIDE AVENUE, SUITE E ACCESS HOME CARE, LLC CHUBBUCK, ID 83202 SUMMARY STATEMENT OF DEFICIENCIES PROVIDER'S PLAN OF CORRECTION (X4) ID (X5) COMPLETE PRÉFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX (EACH CORRECTIVE ACTION SHOULD BE TAG REGULATORY OR LSC IDENTIFYING INFORMATION) CROSS-REFERENCED TO THE APPROPRIATE DATE TAG DEFICIENCY) N 001 Continued From page 1 N 001 to provide basic care and services to patients and to coordinate care. The findings include: 1. Refer to N44 as it relates to the failure of the agency to ensure the administrator provided sufficient organization and direction to agency staff to ensure basic services and processes would be defined and provided. 2. Refer to N51 as it relates to the failure of the agency to ensure current CPR certifications were maintained for employees who provided direct care to patients. 3. Refer to N62 as it relates to the failure of the agency to ensure care was effectively coordinated with outside entities that also provided care to agency patients. 4. Refer to G123 as it relates to the failure of the agency to ensure OT services were provided as ordered. 5. Refer to N152 as it relates to the failure of the agency to ensure POCs were developed for private pay and other patients. The cumulative effect of these negative systemic agency practices resulted in the agency's inability to provide consistent services to patients. N 044 03.07021. ADMINISTRATOR N 044 N044-1/6/2009

N044 021, ADMINISTRATOR, An

administrator shall be appointed by

implementing the policies and programs

the governing body and shall be

responsible and accountable for

approved by the governing body.

The administrator will ensure that all

patients receive care according to the

initial home health orders and plan of

care, and that all services are being

coordinated effectively with all those

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Bureau of Facility Standards STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X3) DATE SURVEY COMPLETED (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION **IDENTIFICATION NUMBER:** A. BUILDING B. WING\_ 137110 12/03/2008 STREET ADDRESS, CITY, STATE, ZIP CODE

NAME OF PROVIDER OR SUPPLIER

CCES		BUCK, ID 832	JRNSIDE AVENUE, SUITE E ID 83202				
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLE DATE			
P	This Rule is not met as evidenced by: Based on staff interview and review of medical records and agency policies, it was determined the agency failed to ensure the administrator provided sufficient organization and direction to agency staff to ensure basic services and processes would be defined and provided. The agency, through the administrator, failed to ensure that systems were in place to ensure patients were comprehensively assessed, that that systems were in place to ensure patients ha POCs to direct staff in the provision of care, that systems were in place to ensure care was coordinated with other providers who furnished care to agency patients, and that systems were place to ensure occupational therapy services were available to all patients. These omissions affected the care of 8 of 15 patients (#1, #3, #4, #5, #7, #8, #10, and #14) whose care was reviewed. The findings include:  1. The administrator had not ensured a system had been developed and implemented to provide comprehensive assessments to private pay and other patients. This affected the care of 2 of 3 private pay patients (#8 and #14). Examples include:  * Patient #8 was a 14 year old male who was admitted following hospitalization for treatment or injuries received in a motor vehicle accident. These injuries resulted in multiple fractures, including fractures of the left arm and leg, and internal injuries. His SOC was 10/31/08. A hand written "SN Start of Care/Resumption of Care 1.60" form, dated 10/31/08, was included in the record. This served as the comprehensive assessment. The assessment was not signed. The assessment was not signed. The assessment was not complete. The Patient lifty Standards	in .	involved in the patients care. Agency will also coordinate all services being provided including therapy services and with the facility in which the patient is residing. The facilities will have access to the appropriate documentation to allow coordination of care, including the plan of care, verbal orders, daily clinical notes, and other documents deemed necessary to the coordination of care. This will be done according to Agency's policy. Agency's staff has been inserviced and are compliant as of January 6, 2009. (attachment B, Agency's Policy and Procedure #2030 Coordination of Services)				

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FORM APPROVED Bureau of Facility Standards STATEMENT OF DEFICIENCIES (X3) DATE SURVEY (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION AND PLAN OF CORRECTION COMPLETED IDENTIFICATION NUMBER: A. BUILDING B. WING 137110 12/03/2008 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 190 WEST BURNSIDE AVENUE, SUITE E ACCESS HOME CARE, LLC CHUBBUCK, ID 83202 SUMMARY STATEMENT OF DEFICIENCIES (X4) ID PROVIDER'S PLAN OF CORRECTION (X5)(EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX PREFIX (EACH CORRECTIVE ACTION SHOULD BE COMPLETE REGULATORY OR LSC IDENTIFYING INFORMATION) TAG CROSS-REFERENCED TO THE APPROPRIATE TAG **DEFICIENCY**) N 044 Continued From page 3 N 044 Care Coordinator, interviewed on 12/10/08 at 9:00 AM, stated at least one of Patient #8's parents were incarcerated and he had run away from the other parent. The Patient Care Coordinator said the patient lived with his aunt. She said the aunt was working to obtain custody of the minor child. The Clinical Administrator was not sure if the aunt had legal guardianship of the patient or not. This information was not included in the assessment. The assessment stated an "Other family member" took "lead responsibility for providing or managing the patient's care...' The assessment did not state if that person was with the patient at all times or whether the patient needed such assistance. The Patient Care Coordinator stated the patient did not attend school due to his injuries. The patient's educational status and services were not assessed. A home visit was made by the surveyor on 12/2/08 at 1:00 PM. The patient lived in a house with several steep stairs in front and narrow winding stairs leading to the garage. The patient was non-weight bearing when he was admitted. At the time of the visit he was ambulating with a walker with supervision. He was sleeping in a hospital bed in the living room but he stated he was anxious to move back into a room over the garage. This required him to go down stairs into the garage and then climb very narrow steep wooden stairs to the second floor

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over the garage. A hand rail extended only half way down the stairs. An assessment of the environment was also not documented. This was confirmed by interview with the Patient Care Coordinator, on 12/10/08 at 9:00 AM.

\* Patient #14 was a 20-year-old male with a SOC date of 10/21/08. He was admitted to the home health agency following hospitalization after he was involved in an accident which resulted in

Bureau of Facility Standards STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X3) DATE SURVEY (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION COMPLETED IDENTIFICATION NUMBER: A. BUILDING B. WING\_ 137110 12/03/2008 STREET ADDRESS, CITY, STATE, ZIP CODE NAME OF PROVIDER OR SUPPLIER

ACCESS HOME CARE LLC

190 WEST BURNSIDE AVENUE, SUITE E

ACCESS		CHUBBUCK, ID 83202						
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FUL REGULATORY OR LSC IDENTIFYING INFORMATIO	i i	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE			
N 044	Continued From page 4		N 044					
	injuries to his right lower extremity, including fractures as well as skin injuries. The patient a current patient as of 12/3/08. A comprehe assessment had not been documented. On 12/3/08 at 1:20 PM, the Clinical Administrative reviewed the patient's record. He confirmed assessment was completed and stated it was a normal practice to do a comprehensive assessment for private pay patients. The agency's policy for comprehensive assessment as not dated or titled. Page 54 stated, "Ar visit shall be made by a Licensed Profession who will perform the comprehensive assessment" This policy had not been followed.	ent was lensive tor d no vas not ments n initial						
	2. The administrator had not ensured a syst had been developed and implemented to de plans to direct the care provided to patients. Refer to G152 as it relates to the lack of PO place for 2 of 3 private pay patients (#8 and and 4 of 12 other patients (#3 #4, #5, and #7 The Clinical Administrator, interviewed on 12 at 11:30 AM, stated comprehensive POCs who to developed for private pay patients. He astated the other missing POCs had been dedue to the Thanksgiving holiday, however, a "PHYSICIAN LOG BOOK" documented 10 pof care that were not developed until betwee and 13 days after patients' SOC or certificatidates between 10/3/08 and 12/1/08.	evelop						
	3. The administrator had not ensured a systemad been developed and implemented to effectively coordinate care with outside entition Refer to N62 as it relates to the lack of care coordination for patients. A policy addressing coordination of care with facilities where patiented was not present in the policy manual. To attent Care Coordinator, interviewed on	es. g ents						

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION			(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			(X2) MULTIPLE CONSTRUCTION A. BUILDING		(X3) DATE SURVEY COMPLETED	
			137110		B. WING	B. WING		12/03/2008	
					, STATE, ZIP CODE				
				CHUBBU	ST BURNSIDE AVENUE, SUITE E ICK, ID 83202				
(X4) ID SUMMARY STATEMENT OF DEFICIENCIES PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL TAG REGULATORY OR LSC IDENTIFYING INFORMATION)			ID PREFIX TAG	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPF DEFICIENCY)	SHOULD BE COMPLETE				
N 044 Continued From page 5			N 044						
12/10/08 at 11:15 AM, stated the agency had not developed such a policy.									
12/10/08 at 11:15 AM, stated the agency had not developed such a policy.  4. The administrator had not ensured occupational therapists would be available to provide services to patients. Refer to N123 as it relates to the lack of OT services provided to 3 of 4 sampled patients (#1, #7 and #10), who had orders to receive such services. On 12/2/08 at 1:23 PM, the Clinical Administrator confirmed the patients had not received OT evaluations or treatment and the physician had not been notified of this. Further, he stated that the agency was having trouble providing OT services in outlying towns.  N 051 03.07021. ADMINISTRATOR  N051 03.07021. ADMINISTRATOR  N051 03. Responsibilities. The administrator, or his designee, shall assume responsibility for:  e. Personnel records of staff working directly with patients shall include: qualifications, licensure or certification when indicated, orientation to home health, the agency and its policies; performance evaluation, and documentation of attendance or participation in staff development, in-service, or continuing education; documentation of a current CPR certificate; and other safety measures mandated by state/federal rules or regulations.  This Rule is not met as evidenced by: Based on staff personnel files, agency contracts and staff interview it was determined the HHA		123 as it ed to 3 of o had 2/08 at rmed the s or n notified by was	N 051	N051- The administrator will ensure that all personnel records of staff working directly with patients shall be updated and current per agency policy and procedure. All staff will have a current cpr card, and if the cpr card is not renewed in the appropriate amount of time the staff member will no longer be able to have direct patient contact until the CPR certificate is active. All staff are		1/6/2009			
		CPR certificate; and other safety measures mandated by state/federal rules or regulations.  This Rule is not met as evidenced by: Based on staff personnel files, agency contract				compliant as of this day January (2009. (see Policy and Procedure exhibit F)	- 1		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION  (X1) PROVIDER/SUPPLIER/CLI IDENTIFICATION NUMBER  137110			(X2) MULTIPLE CONSTRUCTION  A. BUILDING  B. WING		(X3) DATE SURVEY COMPLETED 12/03/2008				
			STDEET AT				03/2008		
	S HOME CARE, LLC		190 WES	ADDRESS, CITY, STATE, ZIP CODE EST BURNSIDE AVENUE, SUITE E BUCK, ID 83202					
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N 051	failed to ensure the documentation of council of 12 employees (# employee files were that employees had not ensure that CPF properly by the licer include:	administrator mainta urrent CPR certification, #8, #9 and # 11) we reviewed. By not end current CPR the HHR could be administed is a staff. The findirector properties of the certification of the certification of the certification.  If a SW whose date of the certification of the certification of the certification.  If a SP whose date of the certification of the cer	ions for 4 whose nsuring IA could red ngs ersonnel as of hire ord did who The ain a  ntracted  Home es did	N 051					
	03.07021. ADMINIST		Attended to the state of the st	N 062	N062-		1/6/2009		
N062 03. Responsibilities. The administrator, or his designee, shall		The administrator will ensure that all		re that all					

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MUL A. BUILD	TIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED			
137110				B. WING		12/03/2008			
			DRESS, CITY	, STATE, ZIP CODE	1	<u> </u>			
ACCESS HOME CARE, LLC 190 WEST CHUBBUG				T BURNSIDE AVENUE, SUITE E CK, ID 83202					
(X4) ID PREFIX TAG	PRÉFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL		FULL	ID PREFIX TAG	PROVIDER'S PLAN OF CORREC' (EACH CORRECTIVE ACTION SHOI CROSS-REFERENCED TO THE APPR DEFICIENCY)	JLD BE	(X5) COMPLETE DATE		
N 062 Continued From page 7 assume responsibility for:			N 062	patients receive care according t					
	· ·				initial home health orders and pl				
	i. Insuring that t				care, and that all services are be	- 1			
	record and minutes of case conferences establish that effective interchange, reporting, and coordination of patient care between all agency personnel caring for that patient does occur.				coordinated effectively with all t				
					involved in the patients care. Ag				
					will also coordinate all services b	_			
	caring for that patier	nt does occur.			provided including therapy servi				
	This Rule is not me	t as evidenced by:			with the facility in which the pati				
	Based on staff interview and review of clinical				residing. The facilities will have a				
	records and agency policies, it was determined the agency failed to ensure care was effectively coordinated with RCF's that also provided care to 2 of 2 agency patients (#3 and #4). Further, it was determined the agency failed to ensure care				to the appropriate documentation	n to			
					allow coordination of care, include	ling			
					the plan of care, verbal orders, d	aily			
					clinical notes, and other docume	nts			
	was effectively coord services for 3 of 4 pa			deemed necessary to the coording	nation				
	received OT and/or	revented		of care. This will be done accord		į			
	agency and facility st	gether to		Agency's policy. Agency's approp	-				
	improve the health o			staff have been inserviced and ar	1				
	include:				e ·				
	1. Patient #4 was a 6			compliant as of January 6, 2009.					
	diagnoses of type II	diabetes and chronic	kidnev		(attachment B, Agency's Policy ar	- 1			
	disease. Her SOC was 11/19/08. Agency				Procedure #2030 Coordination of				
	nursing notes docum twice a day for insulir				Services Exhibit E)				
	of coordination of car	re between the agen	cy and						
	an RCF where the pa	atient lived was not p	resent						
	in the patient record.	The Patient Care							
	Coordinator, interviev	wed on 12/2/08 at 9:5	50 AM,						
	confirmed there was no documentation of care coordination. A visit was made to the RCF on								
	12/3/08 at 8:15 AM a			-					
ļi	nterviewed. The nur	se stated agency sta	ff had			j			
r	not provided the RCF	with a copy of the p	atient's						
	OC or other written						ļ		
	patient's care. The nu requested this information								

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION  A. BUILDING  B. WING			(X3) DATE SURVEY COMPLETED	
· 137110				B. WING		12/0	12/03/2008	
NAME OF PROVIDER OR SUPPLIER STREET AD				DRESS, CITY,	, STATE, ZIP CODE			
				T BURNSID CK, ID 832	E AVENUE, SUITE E 02			
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N 062	Continued From pa	ge 8		N 062				
	had not been provic	led.						
PRÉFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL		at patient ome ent of ated on RCF patient 2 eiving PT to the s RCF ord did for alth at 2:40 AM, ad not id she how staff ere exy ted the essed such as ervices eith a patient at 2:40 AM, and not id she how staff ere exy ted the essed such as ervices ervices.						

		(X1) PROVIDER/SUPPLIE IDENTIFICATION NU		(X2) MULTI A. BUILDIN B. WING _	PLE CONSTRUCTION  G	(X3) DATE : COMPL			
ACCESS HOME CARE II C			190 WES	STREET ADDRESS, CITY, STATE, ZIP CODE  190 WEST BURNSIDE AVENUE, SUITE E CHUBBUCK, ID 83202					
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	ACCESS HOME CARE, LLC  (X4) ID SUMMARY STATEMENT OF DEFICIENCIES PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		d not gency eatment he ent had eatment. Ouble he atment. with a sting the y." On ysician of hip of had not ent. On crator ed the atient home atient or ed to received with a ed on e health ased	N 062					

FORM APPROVED Bureau of Facility Standards STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X3) DATE SURVEY (X2) MULTIPLE CONSTRUCTION AND PLAN OF CORRECTION **IDENTIFICATION NUMBER:** COMPLETED A. BUILDING B. WING 137110 12/03/2008 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 190 WEST BURNSIDE AVENUE, SUITE E ACCESS HOME CARE, LLC CHUBBUCK, ID 83202 SUMMARY STATEMENT OF DEFICIENCIES (X4) ID PROVIDER'S PLAN OF CORRECTION (X5) COMPLETE ID PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL (EACH CORRECTIVE ACTION SHOULD BE **PREFIX** REGULATORY OR LSC IDENTIFYING INFORMATION) TAG CROSS-REFERENCED TO THE APPROPRIATE TAG DATE DEFICIENCY) N 062 Continued From page 10 N 062 several times a day" with bathing, dressing, toileting, transferring, ambulation, medications. meals, housekeeping, and laundry. The patient's record contained a physician's order that was not dated, requesting the agency to provide "Occupational Therapy." The record did not contain documented evidence that she had received an OT evaluation and/or OT treatment On 12/2/08 at 3:57 PM, the Clinical Administrator confirmed the patient had not received an OT evaluation. The record did not contain documentation that the OT had been notified of the referral. The agency failed to coordinate services and the patient did not receive an OT evaluation and/or treatment. Further, Patient #10's nursing assessment dated 9/23/08, stated the patient was depressed. The patient's record contained a physician's order. dated 9/23/08, requesting the agency to provide a SW consult. The record did not contain documented evidence that the patient was provided a SW consult. On 12/2/08 at 3:57 PM, the Clinical Administrator confirmed the patient had not received an SW consult.

was interviewed. She stated that IDT meetings were held weekly but only nursing attended the meetings. She stated that if PT and OT did not get their notes in it caused problems with coordination. She reviewed Patient #7s and #10s record. She stated the agency needed a better checks and balance process for OT referrals and coordination of services

6. On 12/3/08 at 1:50 PM, the Coordination Nurse

N 119 03.07024.04.SK.NSG.SERV.

N119 04. Supervisory Visits. A registered nurse or therapist makes a N 119-

The administrator will ensure that all

1/6/2009

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N 119

PRINTED: 12/18/2008 FORM APPROVED Bureau of Facility Standards STATEMENT OF DEFICIENCIES (X3) DATE SURVEY (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION AND PLAN OF CORRECTION COMPLETED IDENTIFICATION NUMBER: A. BUILDING B. WING 137110 12/03/2008 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 190 WEST BURNSIDE AVENUE, SUITE E ACCESS HOME CARE, LLC CHUBBUCK, ID 83202 SUMMARY STATEMENT OF DEFICIENCIES PROVIDER'S PLAN OF CORRECTION (X4) ID (X5) (EACH DEFICIENCY MUST BE PRECEDED BY FULL PRÉFIX PREFIX (EACH CORRECTIVE ACTION SHOULD BE COMPLETE REGULATORY OR LSC IDENTIFYING INFORMATION) CROSS-REFERENCED TO THE APPROPRIATE TAG DATE TAG DEFICIENCY) N 119 Continued From page 11 N 119 aide supervisory visits will be done by supervisory visit to the patient's the appropriate supervisor either an residence at least every two (2) Registered Nurse or a Physical weeks, either when the aide is present to observe and assist, or when the Therapist, at least every 14 days. All aide is absent, to assess supervising staff have been inserviced relationships and determine whether on this and are compliant as of this day goals are met. For patients who are receiving only home health aide January 6, 2008. (see attached policy services, a supervisory visit must be and procedure #8047) made at least every sixty (60) days. This Rule is not met as evidenced by: Based on staff interview and review of clinical records and agency policies, it was determined that, the agency failed to ensure that RNs or physical therapists had made supervisory visits to patients' homes no less frequently than every 2 weeks, for 5 of 8 sampled patients (#1, #5, #9, #10 and #15) who received home health aide services. This prevented the agency from ensuring HHAs provided safe and effective care to patients. The findings include: 1. Patient #1 was a 66-year-old female with a SOC date of 2/1/08. She was admitted to the home health agency following a hospitalization when she was found to have a minimally displaced femoral neck fracture and underwent hip surgery. The patient was discharged from the agency's service on 3/6/08. The patient's POC. dated 2/1/08, stated the HHA would see the patient 1-2 times a week for six weeks. The

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patient also received PT services 1 time for the first week and 2-3 times a week for 6 weeks. The patient was seen by the HHA on 2/5, 2/7 and

supervisory HHA visit during her time of services. On 12/2/08 at 1:23 PM, the Clinical Administrator

2/29/08. The record did not contain documentation that PT staff had made a

confirmed that the PT had not made a

	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIE IDENTIFICATION NU		(X2) MUL A. BUILD B. WING		(X3) DATE COMP	SURVEY LETED
		137110		D. WING		12/	/03/2008
NAME OF F	PROVIDER OR SUPPLIER		STREET AD	DRESS, CITY	, STATE, ZIP CODE		
ACCESS	HOME CARE, LLC			T BURNSIE CK, ID 832	DE AVENUE, SUITE E 02		
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N 119	Continued From pa	ge 12		N 119			
	agency's policy for I dated or titled. Pag supervisory visitse was not followed.  2. Patient #9 was ar SOC date of 7/22/08 home health agency a myocardial infarct current patient as of dated 7/22/08, state patient 1-2 times a view However, HHA servisix weeks of service receiving skilled nur	n 86-year-old male was. He was admitted of following a hospitation. The patient was 12/2/08. The patier dethe HHA would select week for nine weeks. Inces were discontinus. The patient was alsing services 1 to 3 to 3 to 25.	ith a to the ization for a the et after so imes a				
	week for 3 weeks. If 2 to 3 times a week seen by the HHA on 8/12, 8/15, 8/19, 8/2 did not contain docu staff had made the rivisits during the six v12/2/08 at 2:21 PM, confirmed the supercompleted.	T was also to see the for 9 weeks. The part 7/25, 7/28, 8/1, 8/4, 1 and 8/26/08. The mentation that nursing the cessary supervisors weeks of HHA's servithe Clinical Administ	ne patient dient was 8/8, record ng or PT y HHA dice. On rator				
	3. Patient #10 was a SOC date of 9/23/08 11/13/08. She was a agency due to being fatigue, weakness, C confusion. The nurs 9/23/08, stated the p several times a day" toileting, transferring, meals, housekeeping POC, dated 9/23/08, the patient was also receipted.	3. She was discharg admitted to the home a high fall risk, incre VA, depression and ing assessment, date atient needed "assis with bathing, dressin, ambulation, medical, and laundry. The stated the HHA wouleek for six weeks. The	ed on health ased ed tance lg, tions, patient's ld see				

	STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION  (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			(X2) MUL A. BUILD	TIPLE CONSTRUCTION ING	(X3) DATE COMP	SURVEY LETED
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NAME OF	PROVIDER OR SUPPLIER		STREET AD	DRESS, CITY	, STATE, ZIP CODE		
ACCESS	S HOME CARE, LLC	,		T BURNSII CK, ID 832	DE AVENUE, SUITE E 102		
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	services. The patie 9/27, 10/20, 10/27 a not contain docume made supervisory F	ent was seen by the Fand 11/10/08. The restation that nursing a HAA visits. On 12/2/0 ministrator confirmed to the supervisory HH an 80-year-old male of 1/08, and was a currence survey. He was accepted the HHA would see the patient was also received a supervisory HHAPM, the Clinical Adming staff had not mad the patient's home.  188 year old female was a see the patient's home.  188 year old female was a see the patient's home.  188 year old female was a see the patient's home.  1930, 10/1, 10/7, 10/10/28, 10/30, 11/4, 10/10/28, 10/30, 10/30, 11/4, 10/10/28, 10/30, 10/30, 11/4, 10/10/28, 10/30, 10/30, 11/4, 10/10/28, 10/30, 10/30, 10/30, 10/30, 10/30, 10/30, 10/30, 10/30, 10/30, 10/30, 10/30, 10/30, 10/30, 10/30, 10/30,	ecord did staff had 18 at 3:57 I that the A visits to with a nt patient dmitted to d POC, see the starting ving seen by 10/31, The ence that visits inistrator e with er SOC 19, 11/6/, ted on ere During ered ented. I on	N 119			

,	STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/C IDENTIFICATION NUMBER			(X2) MUL A. BUILDI	TIPLE CONSTRUCTION	(X3) DATE ( COMPL	
		137110		B. WING12			
NAME OF I	PROVIDER OR SUPPLIER		STREET AD	DRESS, CITY	, STATE, ZIP CODE	12/	03/2008
ACCESS	HOME CARE, LLC			T BURNSIE CK, ID 832	DE AVENUE, SUITE E 02		
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N 123	Continued From pa	ge 14		N 123	N 123-		1/6/2009
N 123	N123 025. THERAP' N123 025. THERAP' therapy services off directly or under arrigiven by a qualified qualified therapy assupervision of a qualified and in accordance vicare.  This Rule is not me Based on review of interview, it was detensure therapy serviordered by the physipatients, who had or (#1, #7 and #10). The evaluations and treating findings include:  1. Patient #1 was a SOC date of 2/1/08. home health agency a minimally displaced.	Y SERV.  APY SERVICES. Any fered by the HHA angement are therapist or by a sistant under the alified therapist with the plan of the as evidenced by: clinical records and sermined the agency ices were provided a ician for 3 of 4 samproders to receive OT shis resulted in omittee the therapist of the services was admitted to following a hospitalized femoral neck fractive.	staff failed to is led services d ents. The with a o the zation for	N 123 N 123	The administrator will ensure ordered disciplines including to and social services will be start the appropriate time frame are coordinated according to Poli Procedure #2030 (coordinated services). All appropriate staff been inserviced on this policy compliant as of January 6, 200	therapy rted within nd cy and on of ff have and are	1/6/2009
	underwent a right hip discharged from the A "Intake/Referral" for a nurse stated, the act of services to improve her gait and patient's POC dated received assistance viving from a "couple fat home" and the age record contained a phase of the provided an OT enable of the provided an OT enable of the provided an OT enable from the provided an OT enables.	agency's service on orm, dated 2/1/08, wrogency was to provide the strength, mobility range of motion. The 2/1/08, stated the pawith her activities of the came in and help and the patency's HHA. The patency's order datency agency to provide by." The record did evidence that the agency to provide the strength of the s	3/6/08. itten by PT and and ite tient daily lped her iient's d				

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Bureau of Facility Standards

	STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			(X2) MULT A. BUILDI B. WING	***************************************	(X3) DATE S	ETED
		137110					03/2008
1	B HOME CARE, LLC		190 WES		STATE, ZIP CODE DE AVENUE, SUITE E 02		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIE  MUST BE PRECEDED BY SC IDENTIFYING INFORMA	FULL	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE AC' CROSS-REFERENCED TO DEFICIENCE	TION SHOULD BE THE APPROPRIATE	(X5) COMPLETE DATE
	to the patient. On 1 Clinical Administrate not received an OT the physician had not received the physician had not received and of the physician had not received the providing OT The patient did not read and/or treatment per 2. Patient #7 was a SOC date of 11/24/0 as of 12/02/08. She health agency follow 11/11/08. The nursi 11/24/08, stated the several times a day'	2/2/08 at 1:23 PM, the confirmed the patient the agency was in the property of the patient and said the patient to receive an OT evaluation and/or treatment to receive appropriation of the patient to receive appropriation and/or treatment and said the patient and said the physical a	ent had ent and is. having towns. ation  with a h patient home on ed sistance ng, oing and a sting the y." On hysician of hip had not ent. On rator ed the ent n OT sician did not ent per with a ed on health	N 123			

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	FEMENT OF DEFICIENCIES PLAN OF CORRECTION  (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			A. BUILDI		(X3) DATE SURVEY COMPLETED
		137110		B. WING		12/03/2008
NAMEOFF	PROVIDER OR SUPPLIER				STATE, ZIP CODE	
ACCESS	HOME CARE, LLC			CK, ID 832	E AVENUE, SUITE E 02	
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N 123	Continued From pa	ge 16		N 123		
	9/23/08, stated the several times a day toileting, transferring meals, housekeeping record contained a dated, requesting the "Occupational Therecontain documentation and/oat 3:57 PM, the Clinthe patient's record documentation that OT evaluation. He documented eviden	rsing assessment dat patient needed "assi patient needed "assi "with bathing, dress g, ambulation, medicing, and laundry. The physician's order, the agency to provide apy." The record diction that she had recor OT treatment. On ical Administrator reand confirmed there the patient had recefurther could not find ce that the physician above. The patient ation and/or treatment.	stance ing, cations, e patient's at was not l not eived an 12/2/08 viewed was not ived an had did not		N 152-	1/6/2009
	03.07030.01.PLAN  N152 01. Written F written plan of care s developed and imple patient by all discipli services for that pati follows the written pl includes:  This Rule is not me Based on staff interv records and agency the agency failed to provide services con of 3 private pay patie non-private pay patie and #15) whose recoresulted in the inabili care was provided in findings include:	Plan of Care. A shall be emented for each nes providing ient. Care lan of care and t as evidenced by: view and review of m policies, it was deter develop, implement, esistent with the POCents (#8 and #14) and the state of the agency to extend to the sente of the agency to estable the sente of the agency to estable the sente of the agency to estable the agency the agency to estable the agency the agency to estable the agency the agency to estable the agency t	mined and/or cs for 2 d 7 of 12 t7, #10, This nsure	N 152	The administrator will ensure the patients referred to agency will happropriately assessed and admithe agency according to policy as procedure #2008 (Attachment A administrator will also ensure the following the evaluation, a hand Plan of Care will be sent to the physician for signature for orders home health disciplines in the intime period that the 485/plan of being processed, audited, and da entried by the agency (This form found as attachment C). The administrator will also ensure the physician will be notified of any respectively.	tted to and

	PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MUL1 A. BUILDII	FIPLE CONSTRUCTION	(X3) DATE S COMPL	
	137110	B. WING		12/0	3/2008
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ACCESS HOME CARE, LLC	190 WES		E AVENUE, SUITE E		
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injuries received in a mo These injuries included internal injuries. His SO 12/2/08, he did not have The Clinical Administrate	rear old male who was italization for treatment of otor vehicle accident. several fractures and of was 10/31/08. As of a comprehensive POC. or, interviewed on 12/2/08 patient was a private pay or said agency staff did OCs for private pay or said	N 152	visits that are not following the Care (see attachment D). All appropriate staff have been in on these policy and procedure compliant as of January 6, 200	nserviced es and are	

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	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIE IDENTIFICATION NU		(X2) MUL A. BUILDI	TIPLE CONSTRUCTION	(X3) DATE S COMPL	
		137110		B. WING	504444654444644444444444444444444444444	12/0	03/2008
NAME OF F	PROVIDER OR SUPPLIER		STREET AD	DRESS, CITY	, STATE, ZIP CODE		
ACCESS	HOME CARE, LLC			F BURNSIE CK, ID 832	DE AVENUE, SUITE E 02		
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N 152	Continued From pa	ge 18		N 152			
	a week. Review of documented that th POC for Patient #3. contain physician's services. The recording written by a PA, dat Evaluation". This with the RN assigned 9:00 AM. The agent follow a POC.  4. Patient #4 was a diagnoses of type II disease. Her SOC of documented she was insulin injections. A SOC, a POC had no staff. The Director of 12/1/08 at 3:15 PM,	e agency had not de Further, the record orders for nursing ar only contained an ed 11/22/08, for a "Hous confirmed by intered to the patient, on acy failed to develop and diabetes and chronious being seen twice as of 12/1/08, 12 days of Home Care, intervistated the POC had staff had been too b	veloped a did not hid PT order lome erview 12/2/08 at and with a kidney ng notes a day for a after the y agency iewed on not been				•
	diagnoses of joint pa was 9/24/08. Her no	I Administrator, inter AM, stated the POC I 12/1/08. 71-year-old female w 8. She was a currer was admitted to the ing a left hip surgery nt had a history of dia anemia, hypertension	er SOC d started until iod viewed had not with a nt patient home on abetes n, back				

PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX (EACH CORRECTIVE ACTION SHOULD BE COM	1	MENT OF DEFICIENCIES AN OF CORRECTION	(X1) PROVIDER/SUPPLIE IDENTIFICATION NUI		(X2) MUL	TIPLE CONSTRUCTION	(X3) DATE S COMPL	
NAME OF PROVIDER OR SUPPLIER  ACCESS HOME CARE, LLC  SUMMARY STATEMENT OF DEFICIENCIES CHUBBUCK, ID 83202  (X4) ID PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)  N 152  Continued From page 19  physician ordered skilled nursing, OT and PT services on 11/19/08. The "Comprehensive Assessment", dated 11/24/08, stated the patient needed "assistance several times a day" with bathing, dressing, toileting, medications, meals, housekeeping and laundry. The patient also had a surgical wound that needed monitoring. Review of the patient's record documented that the agency had not developed a POC for patient #7. On 12/3/08 at 10:30 AM, the Clinical Administrator stated the patient's POC had not been developed due to the holiday and the fact			137110				12/0	03/2008
CHUBBUCK, ID 83202  (X4) ID PREFIX TAG  (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)  N 152  Continued From page 19  physician ordered skilled nursing, OT and PT services on 11/19/08. The "Comprehensive Assessment", dated 11/24/08, stated the patient needed "assistance several times a day" with bathing, dressing, toileting, medications, meals, housekeeping and laundry. The patient also had a surgical wound that needed monitoring. Review of the patient's record documented that the agency had not developed a POC for patient #7. On 12/3/08 at 10:30 AM, the Clinical Administrator stated the patient's POC had not been developed due to the holiday and the fact	NAME OF	F PROVIDER OR SUPPLIER		STREET AD	DRESS, CITY	, STATE, ZIP CODE		
PRÉFIX TAG  (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)  N 152  Continued From page 19  physician ordered skilled nursing, OT and PT services on 11/19/08. The "Comprehensive Assessment", dated 11/24/08, stated the patient needed "assistance several times a day" with bathing, dressing, toileting, medications, meals, housekeeping and laundry. The patient also had a surgical wound that needed monitoring. Review of the patient's record documented that the agency had not developed a POC for patient #7. On 12/3/08 at 10:30 AM, the Clinical Administrator stated the patient's POC had not been developed due to the holiday and the fact	ACCES	SS HOME CARE, LLC						
physician ordered skilled nursing, OT and PT services on 11/19/08. The "Comprehensive Assessment", dated 11/24/08, stated the patient needed "assistance several times a day" with bathing, dressing, toileting, medications, meals, housekeeping and laundry. The patient also had a surgical wound that needed monitoring. Review of the patient's record documented that the agency had not developed a POC for patient #7. On 12/3/08 at 10:30 AM, the Clinical Administrator stated the patient's POC had not been developed due to the holiday and the fact	PREFIX	X (EACH DEFICIENCY	MUST BE PRECEDED BY	FULL	PREFIX	(EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE	SHOULD BE	(X5) COMPLETE DATE
services on 11/19/08. The "Comprehensive Assessment", dated 11/24/08, stated the patient needed "assistance several times a day" with bathing, dressing, toileting, medications, meals, housekeeping and laundry. The patient also had a surgical wound that needed monitoring. Review of the patient's record documented that the agency had not developed a POC for patient #7. On 12/3/08 at 10:30 AM, the Clinical Administrator stated the patient's POC had not been developed due to the holiday and the fact	N 152	52 Continued From pa	ge 19		N 152			
patients during that past week.  7. The agency maintained a "PHYSICIAN LOG BOOK" for tracking documents sent to physicians. The log book tracked POCs sent between 10/3/08 and 12/1/08. The Office Manager maintained the the log. The log book documented 10 plans of care that were not developed until between 8 and 13 days after their SOC or certification dates. The Office Manager confirmed this during an interview on 12/2/08 at 10:00 AM.  8. Patient #1 was a 66-year-old female with a SOC date of 2/1/08. She was admitted to the home health agency following a hospitalization for a minimally displaced femoral neck fracture and underwent a right hip surgery. The patient was discharged from the agency's service on 3/6/08. The patient's POC, dated 2/1/08, stated the HHA would see the patient 1-2 times a week for six weeks. The patient was seen by the HHA on 2/8/08, and was not seen again by the HHA until 2/29/08. The patient did not receive HHA services during the 2nd, 3rd and the 4th week of service. The record did not contain documented		physician ordered s services on 11/19/0 Assessment", dated needed "assistance bathing, dressing, to housekeeping and I a surgical wound the Review of the patient the agency had not #7. On 12/3/08 at 1 Administrator stated been developed due that the agency had patients during that  7. The agency main BOOK" for tracking physicians. The log between 10/3/08 and Manager maintained documented 10 plandeveloped until betw SOC or certification confirmed this during 10:00 AM.  8. Patient #1 was a SOC date of 2/1/08. home health agency a minimally displaced underwent a right hip discharged from the The patient's POC, of would see the patient weeks. The patient weeks. The patient 2/8/08, and was not s 2/29/08. The patient services during the 2	skilled nursing, OT and B. The "Comprehend 11/24/08, stated the eseveral times a day olleting, medications, laundry. The patient at needed monitoring of the record document developed a POC for 10:30 AM, the Clinical of the patient's POC he to the holiday and the admitted several of past week.  Italianed a "PHYSICIAN documents sent to book tracked POCs of 12/1/08. The Office of the the log. The log is of care that were not even 8 and 13 days a dates. The Office M g an interview on 12/2 66-year-old female where the second service on lated 2/1/08, stated the the log is service on lated 2/1/08, stated the the log is service on lated 2/1/08, stated the did not receive HHA and, 3rd and the 4th wind, 3rd and the 4th wind is a second service in the late of the	sive e patient with meals, also had g. ed that r patient l ad not he fact new N LOG sent e g book not differ their anager 2/08 at with a o the zation for ure and nt was 3/6/08. he HHA or six A on HA until eveek of	N 152			

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		137110		B. WING	Machine William Control of the Contr	12/0	3/2008
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N 15	2 Continued From page	ge 20		N 152			
	physician of the mis PM, the Clinical Ad missed visits. She notified. She said i to notify physicians agency provided fe physician had order altered the POC an physician.  9. Patient #10 was: SOC date of 9/23/01/13/08. She was agency due to being assessment dated an eeded "assistance bathing, dressing, to ambulation, medical and laundry. The pistated the HHA would week for six weeks. HHA on 9/27/08 and HHA until 10/20/08.	ssed visits. On 12/2/ministrator confirmed stated the physician t was not the agency' of patient missed viswer visits than what the and therefore, the dand therefore, and the patient did not repatient was seen again. The patient was seen again. The patient did not repatient did not rep	the was not spractice its. The he agency dithe with a ged on e health nursing atient with eeping '23/08, ce a en by the by the eceive at the aw the of ian's ecord gency missed it so not be an what the ent ressed. n's				

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	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIE IDENTIFICATION NU		A. BUILDIN		(X3) DATE S COMPL	
		137110		B. WING_		12/0	03/2008
	PROVIDER OR SUPPLIER  HOME CARE, LLC		190 WES		STATE, ZIP CODE E AVENUE, SUITE E 12		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIE  'MUST BE PRECEDED BY SC IDENTIFYING INFORMA	FULL	ID PREFIX TAG	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APP DEFICIENCY)	OULD BE	(X5) COMPLETE DATE
	provide a SW consi documentation that social worker's cons	ult. The record did not the patient was proven the patient was proven the patient was proven the patient of the patient was a current was admitted to the hold increased confusion the patient of the pat	rided a :57 PM, patient  with a t patient ome on and b/16/08, to 3 times 8. The 8 and patient 5th week ded the 3 at 1:10 the d visit. e altered	N 152			